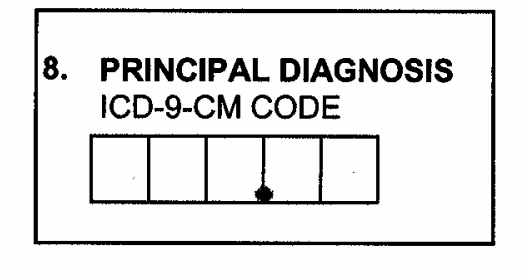
PRINCIPAL DIAGNOSIS — Section 97258

The patient's principal diagnosis, defined as the condition, problem, or other reason established to be the chief cause of the encounter for care shall be coded according to the ICD-9-CM.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for encounters occurring on or after January 1, 2006:



Reporting Requirement:

- A principal diagnosis must be reported for every encounter record.
- Fill from the left-most position and do not skip fields.
- Diagnoses shall be coded according to the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM).
- Duplicate diagnosis codes will not be accepted on the same encounter data record.
- Conditions should be coded that affect patient care in terms of requiring:
    - Clinical evaluation
    - Therapeutic treatment
    - Procedures
    - Increased nursing care and/or monitoring

The following coding systems are not accepted by OSHPD:

- SNODO
- DSM-IV
- Morphology

Refer to the official guidelines on coding and reporting the Principal Diagnoses for outpatient services in *Coding Clinic for ICD-9-CM*.

Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) will never be reported in the Other Diagnosis code fields. Such codes must only be reported in the Principal or Other External Causes of Injury code fields.

Codes from Morphology of Neoplasms (M800-M997) will never be reported in the other diagnosis code field.

Italicized codes will never be the principal diagnosis.